The Health Benefit Exchange and the Small Employer Market

Overview

The federal health care reform law directs states to set up health insurance marketplaces, called "Health Benefit Exchanges," that will enable individuals, families and employers to purchase health insurance from a range of commercial insurers offering a variety of health plans. While the law allows states to defer to the federal government to operate an Exchange if the state chooses not to establish one; Nevada is in the process of establishing the "Silver State Health Insurance Exchange," which will be administered by the State.

Starting in 2014, the Exchange will serve as a central point of access for health insurance, providing eligible individuals, families and small employers with the ability to select from a number of "qualified health plans," offered by a range of insurers. The plans available through the Exchange will have varying amounts of cost sharing and monthly premiums.

Lower- and middle-income individuals and families with income up to four times the Federal Poverty Level (FPL) – which for a family of four is $89,400 in calendar year 2011 – may be eligible for subsidized health insurance (i.e., premium tax credits and reduced out-of-pocket costs) through the American Health Benefit Exchange. Small employers will be able to purchase health coverage through the Small Business Health Options Program or "SHOP" Exchange.

During its first two years of operation, firms with 50 or fewer full-time workers will be eligible to purchase coverage through the SHOP Exchange. In January 2016, employers with up to 100 workers will be able to buy health coverage through the SHOP Exchange. And in 2017, the State may choose to allow large employers (i.e., businesses with over 100 full-time employees) to purchase coverage through the Exchange.

In addition, small employers with 25 or fewer lower-wage workers may be eligible for premium subsidies for up to two years, if they purchase coverage through the Exchange. However, in general, employees that purchase coverage through the SHOP Exchange will not be eligible for premium tax credits and reduced cost-sharing, unless the employees' share of the premium for employer-sponsored coverage exceeds 9.5 percent of the employees' income.

While the law sets out certain requirements, Nevada will need to make a number of key decisions in setting up the Silver State Exchange. This issue brief discusses the key issues and policy decisions associated with the Exchange with regard to the small group market.

One Exchange or Two?

The law allows states to establish two separate Exchanges – a SHOP Exchange for employers and an American Health Benefit Exchange for individuals and families – or a single Exchange to serve the individual and small group markets. It is important to point out that the decision to administer a

single Exchange that serves both markets does not necessarily mean that the individual and small group markets need be, or should be, combined for risk pooling purposes. That is, Nevada may choose to designate a single administrative entity to operate the Exchange for both individuals and employers, while still maintaining separate risk pools for the individual and small group markets.

Many of the requirements of the SHOP Exchange will be identical or similar to those of the individual market Exchange; including, but not limited to, the health plans offered, the summary of benefits information provided to consumers, the rating of health plans based on quality and price, and the health plan reporting requirements.

Both the SHOP and individual Exchange may only offer "qualified health plans" within specific benefit levels: Platinum, Gold, Silver, and Bronze. The benefit levels will vary based on "actuarial value," which is a summary measure of the amount of medical claims paid by the health plan (excluding a member's point-of-service cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Platinum plans will cover 90 percent of the cost of care, which means an individual purchasing a Platinum plan can expect to have 90 percent of his/her medical costs covered by the premium, with the remaining ten percent paid through point-of-service cost sharing (i.e., co-payments, co-insurance, deductibles). Gold plans will cover 80 percent; Silver plans will cover 70 percent; and Bronze plans will cover 60 percent.

However, the individual market Exchange may also offer a high deductible health plan to certain individuals (i.e., under age 30 or people who are exempt from the individual mandate based on affordability of coverage). These plans will not be offered to employers purchasing through the SHOP Exchange.

In addition, the law limits the maximum upfront deductible for health plans purchased by small employers. In 2014, small group health plans may not have an upfront deductible that exceeds $2,000 for single coverage and $4,000 for family coverage.[1] These limits do not apply to the individual market, although the actuarial value standards noted above will effectively cap the amount of upfront deductible that may apply to individual coverage sold through the Exchange.

All plans sold through the Exchange must cover "essential health benefits." The health reform law outlines a basic definition of essential health benefits and requires the Secretary of Health and Human Services (HHS) to further define the essential benefits package. To determine the scope of the essential health benefits coverage, the HHS Secretary must ensure the coverage is equal to the typical coverage provided by an employer, as well as other principles described in the federal law.

The law also requires that health plans in both the individual and group markets comply with a common set of rules, including:

[1] See Appendix for overview of changes to small group market regulations that will take effect in January 2014.

- Guaranteed issue and guaranteed renewal (i.e., an applicant cannot be denied coverage and cannot be dropped at the time of renewal);
- No use of health status as a rating factor (i.e., a person cannot be charged a higher premium based on his/her health status or a pre-existing condition);
- A limited set of factors may be used to set premiums (e.g., age, geographic location, family composition); and,
- Rates may not vary by more than 3:1 based on age (e.g., the rate charged an older applicant is limited to no more than three times the rate charged the youngest applicant).

While health plans sold in the individual and small group Exchange will have common rating requirements; unless the risk pools are combined, the premiums for coverage will likely differ between these two markets. That is, a health plan offered in the individual market may have a different premium than an identical plan offered in the small group market.

Health Plan Selection by Employers and Employees

The manner by which employers – and ultimately employees – may purchase coverage through the Exchange will be one of the most important policy decisions, and will likely determine the ultimate success of the Exchange in serving the small employer market. Key policy decisions include participation requirements, contribution requirements, and the number and type of health plans from which employees may choose. Each is discussed briefly below.

Participation Requirements

Currently, health carriers that offer coverage in the small group market require a minimum percentage of employees to enroll in coverage as a pre-condition for selling group coverage. An employer with five or fewer employees is typically required to enroll all of his/her employees in the group's health plan, unless an employee is covered as a spouse or as a dependent under another employer's plan. For groups of six or more employees, the participation requirement is generally 75 percent. If an employer cannot meet these enrollment thresholds, the health carrier will not sell the policy to the group.

Contribution Requirements

Carriers also require employers to contribute a minimum amount of the monthly premium – generally 50 percent of the premium for single coverage – as a pre-condition for insuring a group. Employers unable or unwilling to contribute at least 50 percent of the premium are not allowed to purchase group insurance.

The participation and contribution requirements protect against adverse selection and the risk of bad debt. Adverse selection describes a situation in which an individual's demand for insurance, and level of coverage, is directly related to the individual's perceived need for insurance. Older and sicker individuals may be more prone to participate in the insurance plan or enroll in the most

comprehensive coverage; while younger and healthier individuals may choose to go without coverage or opt for a more limited health policy.

Because the carriers may not know the health status of the group's members, they are unable to adjust prices to account for this selection bias. By requiring all employees or a majority of employees to be covered by the group policy, the carriers can minimize the potential for adverse selection. The contribution requirement helps reduce the risk of bad debt.

Key policy decisions for the Exchange will be whether the participation and contribution requirements that currently apply to employers purchasing coverage outside of the Exchange will apply to employers that purchase coverage through the Exchange. The Exchange's group purchasing model, discussed below, may also influence policy decisions regarding the contribution and participation requirements.

Employer Purchasing Models – Options for the Exchange

The manners by which employers – and by extension their employees – purchase coverage through the SHOP Exchange will impact the extent to which the Exchange can effectively serve the group market. While there may be any number of purchasing models that one could develop, listed below are four options that the SHOP Exchange may consider. These models are not necessarily mutually exclusive, in that the Exchange may choose to allow employers to select from two or more purchasing options.

One Carrier, One Plan

This model reflects the traditional way that employers, particularly small employers, purchase insurance. The employer selects a carrier and a health plan, and his/her employees are allowed to enroll in the plan. The Exchange platform would be used by the employer – aided, perhaps, by an agent/broker – to compare health plans, assess premium contribution options, and select a carrier and health plan for his/her employees.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	$354	$345	$369

A composite rate could be developed for the group (i.e., a monthly premium for single coverage, employee plus spouse/child, and family coverage), and the employer's and employees' share of the premiums would be set for the entire group.

One Carrier, Multiple Plans

Under this purchasing model, the employer would select a health carrier and allow his/her employees to enroll in any of the health plans offered by that carrier through the Exchange. The table below illustrates how this might be structured. A slight modification to this model might restrict employees' choices to a sub-set of the health plans offered by the carrier.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	**Carrier B**	Carrier C	Carrier D
Platinum	$540	**$531**	$518	$554
Gold	$480	**$472**	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	**$354**	$345	$369

Under this example, the employer "selects" Carrier B and his/her employees may choose from any of the health plans offered by that insurer. The employer could set its share of the premium contribution as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan), as a percentage of all plans' premiums, or as a flat dollar amount. In the example below, if the employee selects the Silver plan, the employee would pay 30% of the cost.

The employee would have the option of taking the employer's contribution – in this case, $289 – and purchase a Gold or Platinum Plan, which would cost the employee more, or a Bronze Plan and pocket the difference in premium. The employer's share of the cost is fixed, while the employee's amount will vary depending on which plan the employee selects. The table below shows how this might work for an individual employee.

Carrier B	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Platinum	$531	$289	$242
Gold	$472	$289	$183
Silver	$413	$289	$124
Bronze	$354	$289	$65

Because employees may select from a number of health plans offered by a single carrier, it is likely that the group's premiums would need to switch from composite rating to list bill rating. Under composite rating, premiums are set on a group basis, and the same rates apply to all individuals and families that enroll in coverage. Under list bill rating, premiums are set for each individual and family that enrolls in coverage.

All Carriers, One Plan Level

Under this purchasing model, the employer would select a plan level (i.e., Platinum, Gold, Silver, or Bronze) and allow his/her employees to select from any of the health carriers within that plan level. The table below illustrates how this might be structured.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	**$420**	**$413**	**$403**	**$431**
Bronze	$360	$354	$345	$369

Under this example, the employer "selects" the Silver Level plan and his/her employees may choose from any of the health carriers that offer a Silver Level plan offered through the Exchange. The employer could set its premium contribution as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan). If the employee selects Carrier B's Silver plan, the employee would pay 30% of the cost.

The employee would have the option of taking the employer's contribution – in this example, $289 – and purchase a Silver Plan from any of the other carriers. The employer's share of the cost is fixed, while the employee's amount will vary depending on which carrier the employee selects. The table below shows how this might work for an individual employee.

Carriers' Silver Level Plan	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Carrier A	$420	$289	$131
Carrier B	$413	$289	$124
Carrier C	$403	$289	$113
Carrier D	$413	$289	$141

Because employees may select from a number of health carriers within a plan level, premiums would need to switch from composite rating to list bill rating, as described above.

All Carriers, All Plans

Under this purchasing model, employees would be allowed to select from any of the health plans offered by the health carriers participating in the Exchange. The employer's share of the premium could vary based on the percentage of the premium (e.g., 70% of any plan's premium), could be set based on the premium of a particular plan offered by a specific carrier (e.g., 70% of the Silver Level Plan offered by Carrier B), or the employer could provide employees with a flat dollar amount and allow them to apply the employer's defined contribution to any health plan offered through the Exchange.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	$413	$403	$431
Bronze	$360	$354	$345	$369

As with the previous two purchasing models, because employees may select from any of the health carriers, premiums would need to be established on a list bill basis.

Each of these models brings with it implications for the Exchange's attractiveness and sustainability, operational and administrative challenges, the potential for adverse selection, and ramifications for the broader commercial insurance market. The Silver State Exchange will need to evaluate the advantages and disadvantages of each purchasing option, and determine which model may work best for Nevada's employers, employees, residents and insurers.

Premium Billing, Collection and Remittance

The need for the Exchange to administer premium billing, collection, and remittance will be particularly crucial. Depending on how the SHOP Exchange structures its purchasing model, employees may be able to choose coverage from a number of health carriers. If the health plans are responsible for premium billing and collection, an employer purchasing coverage through the Exchange would likely need to pay multiple health carriers for, and need to establish contractual relationships with the different carriers selected by his/her employees.

From an employer's perspective, the prospect of paying multiple insurers will greatly diminish the attractiveness and value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for his/her employees' health coverage, by not centralizing the premium billing and other administrative functions within the Exchange, the employer would need to deal with various carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks that are now handled through one health carrier or through a broker.

In light of those administrative challenges, the Exchange may be the appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other mid-year administrative tasks, such as changes in enrollment, COBRA notification, etc. In addition, the Exchange will be responsible for administering the premium tax credits program for eligible small employers that employ low-wage workers. This responsibility might also be better coordinated through a centralized process administered by the Exchange.

Key Issues for Nevada

These and many other issues will need to be addressed as the Silver State Health Insurance Exchange establishes the SHOP Exchange, develops the administrative processes and procedures to offer insurance to employers, and works with health carriers to structure a market that works for the Nevadans.

- Should the State establish one or two Exchanges to serve the individual and group market?
- Should the individual and small group market risk pools be combined or remain separate?
- What type of purchasing model will best meet the needs of employers, employees and insurers?
- Is there a market segment, particularly among small employers, that may be interested in offering employer-sponsored insurance but are unable to meet the minimum participation and/or contribution standards?
- Can the Exchange fill this gap and promote an alternative means by which employers can subsidize insurance on a defined contribution basis that may not meet the 50 percent threshold?
- If the participation and contribution requirements are modified, what might be the effect on the small group risk pool, and should these "groups" be included in the individual market instead of the small group market?
- What might be the effect on the broader small group market from the introduction of an Exchange and the availability of premium subsidies for individuals who are not offered employer-sponsored insurance?

APPENDIX

Nevada's Small Group Market Regulatory Overview

The small group market in Nevada is governed by rating rules established by statute and regulated by the Nevada Division of Insurance (DOI). Guaranteed issue is required (with a maximum exclusion period of 12 months for pre-existing conditions and lapsed coverage). Carriers may develop customized plans to sell in the small group market or standardized plans that have uniform benefit features. There are two standardized plans (Basic and Standard), which may be offered as indemnity, PPO or HMO plans.

Rate development and rate increases for HMOs are regulated by the DOI. Although PPO plans in the small group market are not required to file their rates with the Division, legislation pending in the Nevada Legislature would authorize the DOI to review all small group market products. In addition, many insurers file their PPO products with the Division.

Carriers are permitted under the current guidelines to develop premiums based on a number of specific characteristics. The factors used in underwriting include:

- Group size (i.e., the number of covered lives)
- Age demographics of the group
- Gender mix
- Industry to which the employer group belongs (carriers may establish no more than nine classes of business based on observed and demonstrated differences in cost – administrative or claims - or utilization)
- Geographic area of the state where employees are located
- Family composition of the group (e.g., single, single +1, family)
- Employer's premium contribution level

While health status of the group is not an explicit rating factor, it is used in the Nevada small group market to set rates for particular groups. According to the DOI, the various rating requirements effectively allow carriers to rate for health status with a rating factor limit of 30% across groups for the same or similar coverage

Carriers must stay within certain parameters when structuring their rates. For example, for the industry classification, the rating factor for the highest-risk industry type may not exceed the rating factor for the lowest risk industry type by more than 20%. Premiums offered to like-employers (i.e., those within the same industry type) must be set within certain parameters.

The DOI also has the ability to cap excessive rate increases that are deemed unjustifiable after adjusting for such factors as claims experience and health status specific to a small employer,

premium differences for similarly situated groups, and changes in the make-up/demographics of the group.[2]

The federal health care reform law will require Nevada to make a number of changes to its small group rating rules, and will restrict the number and types of rating factors used to set plan premiums in the small group market, as well as place limits on annual deductibles and require that certain benefits be covered by the health plans sold in the small group market.

For coverage effective January 2014, the federal law requires health plans to cover "essential health benefits." While the specifics regarding what constitutes "essential health benefits" will be further defined by the federal Secretary of Health and Human Services (HHS), the law[3] enumerates a number of services that must be covered by health plans, including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to these federal requirements, Nevada has 44 mandated benefits and services that must be covered by commercial health plans. However, for coverage purchased through the Health Insurance Exchange, the federal law requires that the cost of mandated benefits that exceed the essential health benefits must be paid for by the State.

Nevada will need to review carefully the essential health benefits, which are due to be released in the fall of 2011, and compare those requirements to the State's mandated benefits. A policy decision will then need to be made regarding whether the State will continue to require health plans to cover benefits and services above and beyond the essential health benefits; and, if so, how the State will pay for those benefits for the policies that are purchased through the Exchange.

Furthermore, in the small group market, annual deductibles – that is, out-of-pocket expenses that must be paid by the member for services before the health plan's coverage begins – will be limited to $2,000 for single coverage and $4,000 for family coverage.

[2] State of Nevada, Division of Insurance "Overview of Rating Rules in Nevada", 2011
[3] Section 1302 of the Patient Protection and Affordable Care Act (ACA).

In addition to the rating rules and benefits changes that will take effect in January 2014, by January 2016, the small group market will include businesses with up to 100 employees. Currently, the Nevada small group market is defined as businesses with two to 50 employees.

These changes may affect the number of people covered in the small group market, the number of employers that offer employer-sponsored insurance, as well as the number of carriers offering small group coverage in Nevada. The table below summarizes the rating rules before and after 2014.

Year	**2010**	**2014**
Definition of Small Group	2-50 employees	Up to 50 employees until 2016 (state option); after 2016, up to 100 employees
Covered lives	102,728	Unknown
Guaranteed issue	Yes	Yes
Guaranteed renewal	Yes	Yes
Premium rating factors	• Group size • Age • Gender mix • Industry • Geography • Family composition • Employer's premium contribution • Health status (implicit)	• Age -- 1:3 max ratio • Geography • Tobacco -- 1:1.5 (max) ratio • Family composition • Wellness program -- up to 30% premium discount
Annual deductible limits	None	$2,000 (single) $4,000 (family)
Benefits included in the plan	State mandates	State mandates and "essential health benefits," to be defined by the US Secretary of Health and Human Services
Number of carriers	18	Unknown